CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
Hospital Certification Form

OSH-CCORP 416 (New 7/04)

Healthcare Quality and Analysis Division
818 K Street, Room 200
Sacramento, California 95814
(916) 322-9700 FAX (916) 322-9718

Hospital name: _____ Facility Identification Number: _____

Report period: From: _____ To: _____ **Total records**: _____
(Month) (Day) (Year) (Month) (Day) (Year)

Data collection tool used: CCORP ☐ Society of Thoracic Surgeons (STS) ☐ Other ☐

Number of CCORP Surgeon Certification Forms included with report: _____

Number of responsible surgeons who did not complete a CCORP Surgeon Certification Form: _____

Instructions for Statement of Certification: Write in the space provided the name and California physician license number of each surgeon who did not complete and sign a CCORP Surgeon Certification Form for this report. If the CCORP Surgeon Certification Forms for all responsible surgeons are included with the report, write 'None' in the space provided for the names and license numbers.

Statement of Certification

I, _____, certify under penalty of perjury as follows:
(Name of CEO or designee)

That I am an official of _____ and am duly authorized to submit this California
(Name of hospital)
CABG Outcomes Reporting Program report, and that, to the extent of my knowledge and information, the accompanying data are true and correct, and that the definitions of data elements as set forth in Section 97174 of Title 22 of the California Code of Regulations have been followed by this hospital.

I certify that the following surgeon(s), if any, did not complete a CCORP Surgeon Certification Form and that each was provided the data for the cases assigned to him or her in this California CABG Outcomes Reporting Program report and was given an opportunity to review the data for accuracy and completeness.

Surgeon First Name	*Surgeon Last Name*	*CA physician license no.*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Submit an additional sheet with this form if more space is required.)

I also certify that each surgeon(s) listed above was informed that the data for his or her cases, after any corrections or revisions required by the Office of Statewide Health Planning and Development, will be used to compute his or her risk-adjusted mortality rate for coronary artery bypass graft surgery, and that the Office of Statewide Health Planning and Development will assign data elements with invalid or missing values the lowest risk value as observed in the most current risk-adjustment model for predicting mortality.

Name: _____ Title: _____

Signature: _____ Dated: _____

Address: _____

Telephone: _____ Email: _____